Equity in experience and outcomes

Score: 2

2 - Evidence shows some shortfalls

What people expect

I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals

The local authority commitment

We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.

Key findings for this quality statement

Understanding and reducing barriers to care and support and reducing inequalities

The local authority had regard to its Public Sector Equality Duty (Equality Act 2010) in the way it delivered its Care Act functions; there were equality objectives to reduce inequalities and to improve the experiences and outcomes for people who are more likely to have poor care.

The local authority understood its local population profile and demographics. They had introduced technology to gather data on referrals into Hillingdon Social Care Direct to capture whether the service was accessible to all. Leaders demonstrated both a commitment to address and an awareness of the inequalities across the borough. There were inequalities identified based on deprivation, which was linked to certain parts of the borough, and based on ethnicity and other protected characteristics.

Efforts by the local authority to support the principles were embedded in staff training, person centred ways of working and efforts to engage and co-produce with seldom heard groups. There was no written strategy, but a leader told us a workstream and delivery plan were being implemented. At the time of our assessment there was no data or reported outcomes to demonstrate the impact of initiatives and measures in reducing inequality. Nevertheless relationships were being built and engagement was improving.

Leaders told us during Covid efforts were made to reach out to seldom heard groups and over time this has resulted in trusted relationships with different communities. Community groups created during the pandemic were still active and were used as a gateway to engagement.

Senior leaders recognised hearing the voice of people/communities was an ongoing area for development across the local authority. They had co-production boards but acknowledged the need to widen participation, so they didn't just hear from the same people. Managers gave examples of how efforts to hear from wider communities were being addressed using ballot boxes to hear people's voices, and visits to schools to seek the experience of people with lived experience of care and support needs. Staff were going into the community and working with organisations and people who were supporting disadvantaged and marginalised people such as Muslim communities, Gypsy, Roma and Traveller communities and asylum seekers.

There was recognition some communities, for example the significant Somali community in Hayes, had strong religious and cultural beliefs which meant traditional ways of offering support and engagement were ineffective. The local authority and voluntary sector partners had reached into these communities, through people with the same languages and culture, to better understand and offer support which was accessible. We heard they had been invited to numerous celebrations, such as Eid celebrations alongside local authority members, police and other professionals as guests of groups. This promoted strong community links and good working relationships between community groups and professionals.

Staff told us they have sought and used information and guidance about how to make services equally accessible to people from the LGBTQIA+ community and liaised with another local authority who had developed expertise in this regard. Staff told us there were not enough services for the LGBTQIA+ community, but there was a project to set up access in the local library for advice and signposting services.

It was explicit in domiciliary care contracts providers should be able to meet the needs of any client for whom they were commissioned, in addition to valuing diversity and inclusion strategies. Providers were also asked about the languages their staff spoke, to ensure people were receiving care in their own language. Staff told us of the partnerships they worked with, such as language and interpretation services, MIND charity, and the Hillingdon for All hub which was a consortium early help and wellbeing organisation.

Staff were provided with training in equality and diversity, and there was a staff forum. Examples of cultural awareness training included Gypsy, Roma and Traveller communities, Hate Crime, LGBTQIA+ and Sexual Orientation, Neurodiversity and Learning Disability Awareness.

The local authority told us that 74% of people requiring accommodation-based services such as residential care or supported living, were able to remain in borough. People who needed care and support because of their learning disabilities were however more likely than others to be placed further away from people that they knew, due to a lack of local supported living. This created a risk of disconnection from people that were important to them, which might impact on their wellbeing, and other outcomes.

Inclusion and accessibility arrangements

The local authority had a translation and interpretation service. This was available in over 250 languages for telephone calls, face to face and online meetings, and translation of documentation. The service also had a subscription to a web-based tool which aided understanding and communication for people who find reading text difficult, and a library of easy read documents and could provide large print or braille versions if required. Use of this service was not fully embedded in all teams and a partner organisation told us information was not always being provided in accessible languages by the local authority.

The local authority maintained a spreadsheet listing the languages staff were fluent in, including British Sign Language, and Makaton.

Some people found the online nature of Hillingdon Social Care Direct, and sources of information such as the social care directory, inaccessible. This was because of communication barriers, such as not having English as a first language, or wider barriers to communication caused by their health and care needs. For some people this was simply because they did not have access to the internet. This created an avoidable inequity of experience.

During assessments staff used various tools tailored to the individual's communication preferences. They considered the persons preferences for different types of visuals. They considered where and how the assessment should take place to best support the person to feel safe and engage. They considered other factors such as the individual's engagement levels, preferred time, and medication schedule, which could impact their participation in assessments.

The local authority commissioned a report in 2020 "Making the Council more Autism Friendly" which led to numerous initiatives. An environment checklist was developed which was completed annually. This was used in front facing areas of the local authority and focussed specifically on how the environment might impact on the needs of autistic people.

Staff and leaders were mindful of, and working to address, any accessibility issues or limitations on services offered which might impact more on one group than another. They gave examples of providing additional written guidance to help older people use assistive technology and speaking to catering staff in care establishments about limited menus.

The local authority said that oversight of commissioning and use of the advocacy contract was managed, and that referrals were in line with the requirements of the Care Act. This contrasts with feedback from a partner organisation who felt not all staff had a robust understanding of when and how to use advocacy, which meant that people might not be offered it in a timely manner, to support them to speak up for themselves or engage fully in assessments. Staff also reported instances where delays in safeguarding investigations being completed were caused by delays of 4 weeks in providing a suitable advocate. They noted that this usually took 1-2 weeks. This was inequitable.

Public Health had sought to engage with people about health and wellbeing. Based on feedback about what would be the most accessible way to do so, they had set up a series of craft workshops in a venue known to be trusted by those they wanted to reach. This enabled them to build connections with the community and provided useful information.